State Corporation Commission
Bureau of Insurance
External Appeals
P.O. Box 1157
Richmond, VA 23218
(804) 371-9913

INSTRUCTIONS FOR COMPLETING THE APPEAL OF FINAL ADVERSE DECISION FORM

Please Read Carefully Before Completing the Form

Before completing the attached form, please read the following instructions carefully. We also recommend that you review the form itself as well as the "Important Terms and Definitions" list attached.

The law requires that in order to be "appealable" the actual cost to the covered person of the services or procedures in question exceed $300 if the final adverse decision is not reversed. Please verify the cost of the service(s) before requesting an appeal of a final adverse decision.

1. **Name and Address**
   Please type (or print) the covered person's full name. Include the address, daytime telephone number, date of birth, sex and policy number, certificate number, or other identifying number of the covered person.

2. **Appellant Information**
   This section is to be completed by the appellant who is making the appeal on behalf of the covered person. This section does not need to be completed if the covered person is requesting the external review on his own behalf.

3. **Name of the Managed Care Health Insurance Plan**
   Please provide the name, address and telephone number of the Managed Care Health Insurance Plan (MCHIP). The MCHIP name should be the same as the insurance company or health maintenance organization providing the covered person's coverage. If the covered person is covered by insurance through an employer, please provide the name, address and phone number of the employer, if available.

4. **Describe the Covered Person's Situation**
   Please clearly and accurately describe the nature of the circumstances surrounding the covered person's request for an appeal of a final adverse decision.

5. **Expedited Review**
   In certain situations, an expedited review of an appeal of a final adverse decision may be requested. Please review the definition of "emergency medical condition" provided with this form. If the situation involves an "emergency medical condition," please indicate this by checking the "yes" box and attach supporting documentation.

6. **Treatment for Terminal Conditions**
   Please indicate whether the requested treatment has already been provided and whether, in the opinion of the covered person's treating health care provider, the covered person's condition would be terminal without this treatment.

7. **Filing Fee Waiver**
   Please note that the $50 filing fee may be waived. If you wish to request that the filing fee be waived, please describe the reason or reasons for the request and provide supporting documentation.

8. **Total Cost of Denied Services**
   Please provide an estimate of the total cost to you if services remain denied. If a prescription drug has been denied, please estimate the cost for the length of the prescription. This cost estimate is for our records and will not have any bearing on any party's payment responsibility following the final decision.

9. **Authorization/Authorization to Release Medical Information**

   Please carefully read the "Authorization" section on the "Appeal of Final Adverse Decision" form and the separate "Authorization to Release Medical Information" form included with this package. Information that you provide or authorize to be released may be shared with an impartial health entity. The signature of the covered person or other authorized signature is required on both of these forms in order for the appeal of the final adverse decision to occur.